(d) Eyeglass frames with a cost which exceeds the department's maximum allowable cost;

(e) All contact lenses;

(f) All contact lense therapy, including related materials and services, except where the recipient's diagnosis is aphakia or keratoconus;

(g) Ptosis crutch services and materials;

(h) Prosthetic eye services and materials;

(i) Eyeglass frames or lenses beyond the original and one unchanged prescription replacement pair from the same provider in a 12-month period.

(3) OTHER LIMITATIONS. (a) Eyeglass frames, lenses and related materials shall be provided at wholesale laboratory cost.

(b) Lenses and frames shall comply with ANSI standards (Z-80).

(4) NON-COVERED SERVICES. The following shall be non-covered services and materials:

(a) Anti-glare coating.

(b) Spare eyeglasses or sunglasses.

(c) Services provided principally for cosmetic reasons.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

**HSS 107.21 Family planning services.** (1) COVERED SERVICES. Covered family planning services are those services enumerated below when prescribed by a physician and provided to a recipient, including initial physical exam and health history, annual visits and follow-up visits, laboratory services, prescribing and supplying of contraceptive supplies and devices, counseling services, and the prescribing of medication for specific treatments. All family planning services performed in family planning clinics must be prescribed by a physician, and furnished, directed, or supervised by a physician, registered nurse, nurse practitioner or licensed practical nurse.

(a) Initial physical examination with health history is a covered services and may include the following:

1. Complete obstetrical history including menarche, menstrual, gravidity, parity, pregnancy outcomes and complication of pregnancy/delivery, and abortion history;

2. History of significant illness—morbidity, hospitalization and previous medical care (particularly about thromboembolic disease), breast and genital neoplasm, diabetic and prediabetic condition, cephalelgia and migraine, pelvic inflammatory disease, gynecologic and venereal disease;

3. History of previous contraceptive use;

4. Family, social, physical health, and mental health history, e.g., chronic illnesses, genetic aberrations, mental depression.

2. Vision screening;

3. Hearing screening;

4. Unclothed physical assessment;

5. Immunization status assessment and adminstration of needed immunizations;

6. Oral health assessment;

7. Anemia screening;

8. Developmental testing;

9. Blood lead screening, when indicated by a person's history;

10. Height, weight and head circumference;

11. Blood pressure.

(b) Selection of additional screening tests to supplement the screening package shall be based on the health needs of the target population.

1. Specific racial or ethnic characteristics of the population shall be considered in selection of screening test for specific conditions associated with these factors.

2. Available prevalence rates for specific conditions shall be considered in the selection of disease-specific tests.

3. Consideration shall be given to the existence of treatment programs for each condition for which screening is provided.

(2) Outreach and follow-up services in support of screening, diagnosis and treatment shall be covered when provided by a provider certified according to HSS 105.37 (1) and when performed and documented pursuant to HSS 105.37. Such services shall include:

(a) Outreach which does not result in screening;

(b) Outreach that does result in screening;

(c) Follow-up that does not result in the diagnostic and treatment services indicated by screening results;

(d) Follow-up that does result in the indicated diagnostic and treatment services;

(e) Arrangement for, or provision of, transportation for screening, diagnosis, or treatment services when requested by the recipient and when documented by the provider;

(3) All medically necessary services and items, provided in connection with diagnosis and treatment of conditions uncovered through the EPSDT program shall be covered services, subject to the conditions of HSS 105.37 (3).

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

**HSS 107.23 Transportation.** (1) COVERED SERVICES. (a) Ambulance transportation shall be a covered service if the recipient is suffering from

an illness or injury which contraindicates tranportation by other means and only when provided:

1. From the recipient's residence (or other, e.g., site of an accident) to a hospital or nursing home; or

2. From a hospital or nursing home to the recipient's residence; or

3. From a nursing home to a hospital or from a hospital to a nursing home; or

4. From a hospital to another hospital or from a nursing home to another nursing home; or

5. From a recipient's residence (or nursing home) to a physician's or dentist's office, if other means of transportation are contraindicated and if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnoses or treatment that cannot be obtained in the nursing home or recipient's residence.

(b) Specialized medical vehicle transportation shall be a covered service if the recipient is confined to a wheelchair, or if the recipient's condition contraindicates transportation by common carrier and the recipient's physician has prescribed specialized medical vehicle tranportation. This type of transportation service is covered only if the transportation is to a facility at which the recipient receives medical services.

(c) Transporation, and related travel expenses, by common carrier (e.g., bus, taxi, train, airplane) or private automobile to receive covered medical services is a covered service. Such transportation costs may include the cost of the common carrier or mileage expenses; the cost of meals and commercial lodging enroute to medical care, while receiving the care, and returning from the medical services; and the cost of an attendant to accompany the recipient, if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging and salary of the attendant, except that no salary may be paid to a member of the recipient's family. This transporation service is reimbursed directly to the recipient by the county social services department.

(d) A provider of transportation service may carry more than one recipient at a time.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [Note: For more information on prior authorization, see HSS 107.02 (3).]

(a) All non-emergency transportation by air and water ambulances to receive medical services requires prior authorization.

(b) Non-emergency transportation of a recipient to a provider in another state requires prior authorization by the department unless the non-emergency transportation is for the purpose of receiving services from a provider which is a certified Wisconsin border-status provider.

(c) Non-emergency transportation provided under HSS 107.23 (1) (c) of a recipient to an out-of-state provider, or to a Wisconsin provider if the round trip exceeds 100 miles, must be approved by the county social service department before departure. In either case, the county

agency may require a physician's documentation for the service received at the specific location.

(3) OTHER LIMITATIONS. (a) In instances of hospital to hospital or nursing home to nursing home transfers by ambulance, the ambulance provider shall obtain a certification from the recipient's physician that the discharging institution was not an appropriate facility for the patient's condition, and that the admitting institution was the nearest one appropriate for that condition. Such certification shall contain the reason (s) for which the discharging institution was considered inappropriate and the reasons for which the admitting institution was considered appropriate. The certification shall be signed by the recipient's physician and shall also contain details pertinent to the recipient's condition. A check-off form is not acceptable.

(b) A claim for ambulance tranport to a physician's or dentist's office or clinic shall be accompanied by a separate statement, attached to the claim, which lists the recipient's name; the date of transport; the details about the recipient's condition that preclude transport by any other means; the specific circumstances requiring that the recipient be transported to the office or clinic to obtain a service, and an explanation of why the service could not be performed in the nursing home or recipient's residence; and the dated signature of the physician or dentist performing the service. The services obtained shall be performed by a physician or dentist (or under their direct supervision). Trips to obtain physical therapy, occupational therapy, speech therapy, audiology, chiropractic or psychotherapy shall not be covered.

(c) If specialized medical vehicle transportation is provided to a facility whose function is not primarily medical (e.g. medical supply house, Goodwill Industries) the transportation provider shall obtain from the provider of services at the destination a written statement of the medical services provided. This statement shall accompany the claim for transportation services.

(d) If ambulance or specialized medical vehicle tranportation is to a nursing home for the provision of outpatient services, a statement of services received shall be obtained from the nursing home. This statement shall accompany the claim for transportation service.

(e) Charges for waiting time are covered charges. For non-emergency services, waiting time is allowable only when a continuous trip is being billed.

(f) When the recipient is *not* confined to a wheelchair, a physician's prescription, stating the specific medical problem preventing the use of a common-carrier transportation and the specific period of time the service should be provided, must be obtained. (A check-off form will not be acceptable.) This prescription would be valid for a maximum of one year from the physician's signature date, and the provider must indicate on the claim form that a prescription is on file with the provider, and the name and provider number of the prescribing physician.

(g) Services of an additional specialized medical vehicle transportation attendant are covered only if the recipient's condition requires the physical presence of another for purposes of restraint or lifting.

(h) Services of an additional ambulance attendant are covered only if the recipient's condition requires the physical presence of another for purposes of restraint or lifting. Medical personnel who care for the recipient in transit shall bill the program separately.

(i) If a recipient is pronounced dead by a legally authorized person after an ambulance is called but before the ambulance's arrival, service to the point of pick-up is covered.

(j) If ambulance service is provided to a recipient who is pronounced dead enroute or dead on arrival by a legally authorized person, the entire ambulance service is covered.

(k) Specialized medical vehicle transportation may be reimbursed for unloaded miles, only when the distance from the dispatch point to the pickup point is 20 miles or greater. Such unloaded mileage may only be claimed once when multiple recipients are being carried on one trip.

(4) NON-COVERED SERVICES. The following transportation services are not covered:

(a) Charges for reusable devices and equipment.

(b) Transportation of a recipient's personal belongings only.

(c) Transportation of a lab specimen only.

(d) Charges for sterilization of a vehicle after carrying a recipient with a contagious disease.

(e) Additional charges for services provided at night or on weekends.

(f) If a recipient is pronounced dead by a legally authorized person before an ambulance is called, emergency transportation service is not covered.

(g) Excessive mileage charges resulting from the use of indirect routes to and from medical destinations.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

7.c. **HSS 107.24 medical supplies and equipment.** (1) COVERED SERVICES. The following are covered within the limitations of this section, when prescribed by a physician or other person eligible to prescribe such services [NOTE: These items may not be billed by hospitals or nursing homes, but only by certified providers of the special service.]:

(a) Medical supplies and devices.

(b) Basic and necessary durable medical equipment (e.g., standard wheelchairs, walkers, canes, crutches, hospital beds, bed rails, and mattresses, oxygen equipment and cylinders, braces, casts, home dialysis equipment).

(c) Corrective shoes, with the following frequency rates:

1. Three pair per/year (from original date of service) for children up to 15 years of age; and

2. Two pair per/year for recipients over 15 years of age. These frequencies apply to shoes which are or are not attached to an orthotic brace.

(d) Hearing aids.

(e) Prosthetic and orthotic devices, when provided by either an orthotist or a prosthetist certified as a provider.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. [NOTE: For more information on prior authorization, see subsection HSS 107.02 (3.)] The following services require prior authorization:

(a) Purchase of wheelchairs and prosthetic and orthotic appliances which are not included on the department-approved price tables. Rental of such items requires prior authorization for the second and succeeding months of rental use, except that if rental cost exceeds a dollar amount established by the department and communicated to providers, prior authorization is required before the first month's use. Needed repairs and modifications exceeding the dollar amount established by the department require prior authorization. Replacements of the total appliance unit require prior authorization.

(b) Purchase or rental of all power driven or semi and full reclining wheelchairs and purchase or rental of a wheelchair for a nursing home recipient.

(c) Purchase of hearing aids regardless of cost.

1. Once authorized, the hearing aid is under guarantee for the first year of usage. Any repairs to that aid after the guarantee period must have prior authorization when the dollar amount exceeds an upper limit set by the department and communicated to all hearing aid providers.

2. Hearing aid batteries and accessories do not require prior authorization.

3. Requests for prior authorization of hearing aids shall be reviewed only if such requests consist of the following reports on forms designated by the department, containing information requested by the department:

a. A medical report from the recipient's physician; and

b. An audiological report from an audiologist.

c. After a new or replacement hearing aid has been worn for a 30-day trial period, a performance check shall be obtained from a certified audiologist or certified speech and hearing center. The department shall provide reimbursement for the cost of the hearing aid only after the performance check has shown the hearing aid to be satisfactory, or the lapse of 45 days has occurred with no response from the recipient.

(d) Prior authorization shall be requested and obtained before service is provided. Requests for prior authorization of medical equipment shall be reviewed only if such requests contain the following information:

1. The name, address and medical assistance number of the recipient.

2. The name of the provider and provider number.

3. The name of the person or agency making the request.

4. The attending physician's diagnosis, indication of degree of impairment, and justification for the requested service.

5. An accurate cost estimate if the request is for the rental, purchase, or repair of an item.

6. If out-of-state non-emergency service is requested, a justification for obtaining service outside of Wisconsin, including an explanation of why service cannot be obtained in the state.

7. If the request is for a wheelchair required pursuant to HSS 107.24 (3) (b) 1.b. below, the following additional information shall be included:

a. A physician's order for the wheelchair.

b. A statement by the attending physician that the purchase of a wheelchair will contribute to the rehabilitation of the resident toward self-sufficiency.

(3) OTHER LIMITATIONS

(a) The services covered under this section are not covered for recipients who are nursing home residents or who are inpatients in a hospital, with the following exceptions:

1. Purchase of a wheelchair prescribed by a physician is covered for a nursing home recipient if the wheelchair will contribute towards the rehabilitation of the recipient through maximizing the recipient's potential for independence, and if:

a. The recipient has a long-term or permanent disability and the wheelchair requested constitutes basic and necessary health care for the recipient consistent with a plan of health care; or

b. The recipient is about to transfer from a nursing home to an alternative and more independent setting.

2. Corrective shoes, and prosthetic and orthotic devices.

3. Billing for such services for nursing home recipients shall be in accordance with section 7.09 of this rule.

(b) Hearing aid accessories, batteries and repairs do not require a physician's prescription.

(c) Only items in the following generic categories of medical supplies are covered:

1. Colostomy Appliances

2. Urostomy Appliances

3. Ostomy Appliances

4. Ileostomy Appliances

5. Catheters

6. Incontinence Equipment

7. Irrigation Apparatus

8. Head Halters

9. Parenteral Admin. Apparatus

10. Restraints

11. Support Stockings

12. Trusses

13. Urine Collection (external) Appliance

(4) NON-COVERED SERVICES. The following are not covered:

(a) Temporary breast prostheses.

(b) Medical supplies and devices not included in the categories listed in subsection (3) above, (e.g., heat lamps, hot water bottles, vaporizers, etc.), except when the provider documents to the satisfaction of the department's consultants, that the supply will prevent the recipient from being institutionalized, or that it is required to keep the recipient vocationally occupied, or both.

(c) Durable equipment such as but not limited to: waterbeds, air conditioners, seat lifts, medic-alerts, etc., except when the provider documents to the satisfaction of the department's consultants, that the equipment will prevent the recipient from being institutionalized, or that is required to keep the recipient vocationally occupied, or both.

(d) A visit to a recipient's place of residence by a provider or member of the provider's staff for the purpose of fitting a prosthetic or orthotic device or a corrective shoe.

(e) Repair of rented durable medical equipment.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.

**HSS 107.25 Diagnostic testing services.** (1) COVERED SERVICES. Professional and technical diagnostic services covered by the medical assistance program are laboratory services provided by a certified physician or under the physician's supervision, or prescribed by a physician and provided by an independent certified laboratory and x-ray service prescribed by a physician and provided by or under the general supervision of a certified physician.

(2) OTHER LIMITATIONS.

(a) All diagnostic services shall be prescribed or ordered by a physician, dentist or podiatrist.

(b) Laboratory tests performed which are outside the laboratory's certified area (s) shall not be covered.

(c) Portable x-ray services are covered only for recipients who reside in nursing homes and only when provided in a nursing home.

(d) Reimbursement for diagnostic testing services shall be in accordance with limitations set by federal regulation.

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80.